



OLDER ADULTS LIVING AT RISK: ETHICAL DILEMMAS, RISK, ASSESSMENT AND INTERVENTIONS TO FACILITATE AUTONOMY AND SAFETY

By: Rhiannon Berke, RN, BN rhiannon.berke@albertahealthservices.ca
Faculty of Nursing, Athabasca University, 1 University Drive
Athabasca, AB, T9S 3A3, Canada

ABSTRACT

Older adults (seniors) living at risk are usually identified as adults aged 60 years and older, who are living at home despite having economic, social or physical barriers that affect their overall independence, well-being and quality of life. The purpose of this paper is to provide an overview for nurses and related caregivers of the ethical dilemmas, risk assessment and interventions to facilitate autonomy and safety for this population. Supporting seniors that choose to live at risk is a complex process and represents an ethical dilemma between respecting individual autonomy versus protecting them from harm. Seniors who decide to live at risk are at times questioned, and may require competency and physical assessments to gauge whether there is a clear understanding and appreciation of the consequences of their choices. Interventions and approaches to promote ageing in place safely are described, including the value of the Managed Risk Agreements tool, the role of technology and supportive services. The positive outcomes of the current interventions and approaches discussed reinforce the need for further research in this area of risk management.

Keywords: ageing in place, older adults (seniors), living at risk management, competency

In Canada, the majority (93%) of older adults (hereafter referred to as seniors) live in their own home and wish to stay there for as long as possible (Health Council of Canada, 2012). Seniors living at risk are usually identified as individuals age 60 years and older who continue to live at home despite having economic, social and/or physical barriers that affect their overall independence, well-being and quality of life (The City of Edmonton, n.d, http://www.edmonton.ca/city_government/documents/Environmental_Scan.pdf). Despite some of the negative consequences of living alone, such as falling, malnutrition and self-neglect, many seniors choose to remain living at home because they value the independence it affords. Independence is valued in our society and seniors feel a sense of empowerment being able to maintain some sense of control within their lives, including living at home. This value was described almost two decades ago by nurse researcher, Dr. Carole-Lynne Le Navenec (1996) in her study of how families go about managing a relative with dementia at home. It has also been emphasized more recently in a splendid narrative by the Canadian sociologist, Dr Arthur Frank (2014).

The purpose of this article is to describe six important elements of risk assessment, including the specific roles of the physician and homecare nurse, and the ethical principles involved in these situations. Supportive interventions are also explored, including the rationale for ongoing health care team assessments, the design of innovative programs, provision of agency support services and adaptive equipment, incorporation of technology into the home and the role of *Managed Risk Agreements*. Supporting elderly clients choosing to live at risk is exceptionally challenging, especially when the client's goals are different from those of the health care team (Baker, Campton, Gillis, Kristjansson, & Scott, 2007). Under these circumstances, it is a difficult task to promote client centered care and independence.

In a letter to her children, Nellie Renoux (cited in Baker et al., 2007, para. 9) asked "Is risk not a normal part of life?" Renoux answered it in this way:

When they were young and climbed trees and rode bicycles and went away to camp, I was terrified. But, I let them go, because to hold them back would have hurt them. They're right when they say there are risks. I might fall, I might leave the stove on. But there is no challenge, no possibility of triumph, no real aliveness without risk (Baker et al., 2007, para. 11).

Risk is often viewed as something that needs to be "controlled, managed and minimized" (Millar, 1998, p. 295). particularly for those seniors who (a) are labelled as being "dependent, frail and diseased" (Cheng, 2006, para. 2), or (b) choose to ignore medical advice, refuse placement, experience self-neglect, drive dangerously or live in unsuitable living conditions (Culo, 2011). The idea of failure as a result of taking particular risks in our daily life makes many feel uncomfortable, and as nurses, we are knowledgeable of the duty to ensure the safety of clients in our care by assisting them to minimize risks in their daily lives (Millar, 1998). In our judgements, we label clients as non-compliant and dysfunctional if they do take risks, thereby emphasizing an attitude of intolerance of a client's right to failure. Health professionals often believe that if a client takes a risk and fails, it implies that they have done a bad job. However, it is worth repeating that supporting our clients through failure can help them to develop resilience (Parsons, 2008). Risky situations come along with medical, ethical, legal and social complexities through which questions of capacity, confidentiality and autonomy arise (Culo, 2011).

Ethics

One of the goals set by the World Health Organization (WHO) is to encourage independence in older adults (WHO, 2002). For many seniors, independence is valued as much as life itself and becomes part of their identity (Cheng, 2006). The heart of the dilemma lies in the difference in values between seniors and the healthcare team and informal caregivers (National Advisory Council on Aging, 1993). One of the most difficult ethical dilemmas that arise for nurses and related health care providers who provide community-based services is finding the balance between promoting independence and autonomy for seniors by not interfering with their life goals, and on the other hand, trying to act responsibly and promote health and safety (Kane & Levin, 1998). Kane and Levin (1998), who studied health professionals' views about how acceptable risk-taking differs from unacceptable risk-taking found that almost all respondents in

the study responded with a variant of the phrase “when it does not jeopardize their own safety and that of others” (para. 4). They concluded that many health professionals approved of risk-taking, but only when it was “risk free” in the sense of physical safety (Kane & Levin, 1998).

By contrast, other health professionals contend that taking away the right of older adults to take risks removes their sense of autonomy and control. These professionals would restrict risk taking primarily in those situations that have clearly established dangerous outcomes, such as oxygen dependent clients who elect to take the personal risk of smoking around their oxygen supply, thereby endangering the safety of self and others, as well as property damage. Hence, one of the challenges for this group of healthcare professionals is to be cognisant of situations in which we may need to override the autonomy of older people to prevent harm to themselves or others, or to prevent property damage. As Nay (2002) has indicated, although there are departments that are devoted to risk-management, there do not appear to be any departments pertaining to risk enhancement. Risk management is normally focused on minimizing physical harm and decreasing legal implications for the healthcare system. Nay concludes that “Overzealous risk management may protect a physical body from bruising but it may also damage the irreparably the already vulnerable human soul” (para. 19).

Assessing Risk

Seniors may have an increased risk of harm and accidents in the normal activities of daily living due to losses in physical strength, agility, speed of reaction, vision and hearing (NACA, 1993). Culo (2011) discussed the internal and external risk factors that may lead to this vulnerability:

Internal risk factors include: “increasing age, female gender, medical comorbidities, substance abuse, mental illness, cognitive impairment, sensory impairment, impairments in activities of daily living (ADL) and malnutrition” (para. 8). External risk factors include: “lack of social network, dependence on a care provider, living alone, lack of community resources, inadequate housing, unsanitary living conditions, high-crime neighborhood, adverse life-events and poverty” (para. 8).

Evaluating the degree of risk is a very complex and subjective task and accepting a senior’s decision to live at risk should not involve withdrawal of care and support (NACA, 1993). Needed questions include: Should risk assessment be based on an adverse event that has truly occurred, or on the assessment by health care professionals and family caregivers of the likelihood of an event occurring? Could single events lead to an over-estimation of risk? (Gilmour, 2004)

Determining whether a client is “better safe than sorry” (Kane & Levin, 1998, para. 9) is a complex issue. The following elements should be considered in any assessment of potential risk to a client (Kane & Levin, 1998):

- (1) Type of risk: Psychological, physical, social or financial;
- (2) Severity of consequences: Consequences may be life-threatening, while others may be rather insignificant;

- (3) Likelihood of consequences: Some negative consequences of behavior or actions that are labelled as risky may actually be relatively unlikely to occur;
- (4) Difficulty of predicting risk: Risks associated with home and community-based services are particularly difficult to measure and describe in comparison to those of a surgical procedure;
- (5) Negative effects of avoiding the risk: Decreased autonomy and independence of the client;
- (6) Role of providers: Homecare providers may still be actively involved in a case after their advice has been rejected and may feel obligated to renew the subject of their concerns on a regular basis.

Competency Assessment

Risks can be labelled as tolerable or intolerable. Tolerable risk is consistent with past behavior, does not put others at harm and does not pose imminent life threatening harm to the individual taking the risk (Brown et al., 2013). An illustrative example would be the individual who gets lost when he leaves his home, but is able to return home without incident (Brown et al., 2013). By contrast, intolerable risk, as described by Culo (2011) involves hazardous behavior or circumstances that have the potential to cause serious or impending harm. His examples of intolerable risk include, but are not limited to, physical aggression, abuse and serious self-neglect. He emphasized that if intolerable risk is present, an assessment of decision-making capacity is crucial

According to Moye and Marson (2007), the topic of capacity assessment is dominated by a deep-seated tension between two of the core ethical principles: autonomy and protection (beneficence). Tension is created when one tries to maximize independence and minimise risk simultaneously. The right of seniors to choose to live at risk is restricted by the effects of their decision-making on other people (NACA, 1993). For example, if there is a considerable risk of a fire from a stove being left on in an apartment building, a senior's autonomy must be balanced with the right to a safe environment for the other residents (NACA, 1993).

The National Advisory Council on Aging (NACA; 1993) emphasized that seniors may be deemed incompetent and lose the right to make their own decisions about living at risk based on the outcome of a competency assessment. According to the NACA, three salient issues related to the use of competency assessments are as follows:

- (1) Competency is not "all-or-nothing" (p. 3) and incompetency in one area does not mean that a person is completely incompetent.
- (2) The testing used may not accurately measure the senior's ability to perform many of the activities of daily living. According to the National Advisory Council on Aging (NACA, 1993), this happening may occur in instances wherein the senior fails one aspect of the test, and the assessor automatically assumes other consequence of failure such as the inability to manage one's own finances if the older person was unable to correctly fill out a cheque. The NACA questioned the accuracy of conclusions reached about the ability to make personal decisions that were based solely on the outcome of a single assessment. A senior that is deemed incompetent today may be competent next week and vice versa (NACA, 1993).
- (3) When assessing competency of older adults, educational level, culture and ability to hear or see are not always taken into account (Elder Advocates of Alberta Society, 2013).

The criticisms presented above are not intended to discount the validity and value of a competency assessment; instead, they are reminders to health care professionals that the assessment is subject to bias, must be used with caution and results interpreted cautiously (NACA, 1993). The capacity to appreciate the nature and consequences of a decision must be taken into consideration in the determination of a client's competency (Jenkins, O'Keeffe, Carder, & Wilson, 2006). A majority of cases involving assessment of a client's competency lack a formal process in the assessment process (Jenkins et al., 2006). The creation of a consistent, valid and an unbiased tool to measure a clients understanding and recognition of the consequences of their behaviors or choices in regards to decision-making still stands (Jenkins et al., 2006).

Assessment by a Physician

Culo (2011) indicated a comprehensive assessment of competency of older adults requires collateral information, which may come from a variety of sources ranging from friends, neighbors and family to landlords. According to Culo, the assessment by a physician should include, but is not limited to, the following:

- (1) an interview with the client
- (2) a physical exam
- (3) a medical history
- (4) the best possible medication history
- (5) a basic cognitive test
- (6) screening for psychiatric disorders
- (7) an assessment of functional abilities
- (8) assessment of existing supports
- (9) exploration of potential financial, physical, emotional and sexual abuse
- (10) laboratory and diagnostic studies, and
- (11) assessment of hazards such as medication mismanagement, fire hazards, suicide ideation, risk for falls, issues with driving an automobile, wandering and aggression.

Physical examination, as noted by Culo (2011) is an important assessment component of a senior living at risk because it may reveal issues such as "cachexia, dehydration, malnutrition, burns, bruising, dental decay, decubitus ulcers, odor, lack of cleanliness, and gait abnormalities" which raise suspicion of abuse or self neglect (para. 7). For example, difficulty with performing familiar tasks such as preparing a meal, may lead to symptoms of malnutrition and dehydration that warrant further evaluation by the physician of one's capacity to make and implement decisions. Culo emphasized that support and assistance can be offered once it is determined that intervention is required.

Assessment by the Home Care Nurse

Within Canada, Home Care Nurses in the Yukon, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Newfoundland and Labrador and Nova Scotia (Alberta Health Services, 2011) act as a case manager and use the Resident Assessment Instrument-Home Care (RAI-HC) (Ontario Ministry of Health and Long-Term Care, 2007) to monitor the following populations: those older adults who ...

- (a) are at-risk due to medical conditions that may deteriorate at any time
- (b) may require 24-hour a day supervision, clients with inadequate support systems
- (c) have cognitive disabilities
- (d) have caregivers at risk for burn out
- (e) may be at risk of abuse, neglect and self-neglect.

The RAI-HC assessment instrument has been used to help identify client safety issues in eight provinces and territories in Canada (Canadian Institute for Health Information, 2012). It was developed in the early 1990's as a comprehensive standardized assessment tool to evaluate the "needs, strengths and preferences of adult long-stay individuals in the community" (Ontario Ministry of Health and Long-Term Care, 2007, para. 14). This assessment is repeated every six months for a long-term care client or more frequently when the client has had a significant change in status (Doran et al., 2009). The assessment domains include: cognition, communication and vision, mood and behavior, psychosocial well-being, functional status, continence, disease diagnoses, health conditions, oral and nutritional status, skin condition, medications, treatment and procedures, social supports and caregiver status and environmental assessment (Alberta Health Services, 2011).

According to Doran et al. (2009), the RAI-HC assessment instrument is a source of data for three types of adverse events: (1) "patient falls (2) increased use of health resources, and (3) patient adverse outcomes" (p. 173). These authors found that the RAI-HC identified the most common client safety risks to be: polypharmacy, decline in physical function, cognitive impairment and/or decline in cognitive function, decline in physical function and living alone, and history of two or more falls.

The RAI-HC assessment identifies safety risks that may predispose clients to harm but does not specify whether an adverse event actually occurred. In addition, as Doran et al. (2009) have emphasized, since the assessment is completed every six months on average, there is potential for an adverse event to have occurred and be missed if not divulged by the client or caregiver at the time of assessment. They suggested that further research is needed to investigate the extent to which the combination of risk factors increases a client's susceptibility to a poor outcome and how to gather evidence on best practices for enhancing safety risk assessment. At a health system level, they maintained that policies should be developed to support best practice related to the frequency of medication reviews and resources to support independent living. Their conclusion was that if the Home Care program provided suitable interventions for at-risk clients, such as teaching self-care and coping skills, the consequences would be positive.

Interventions

According to Culo (2011), the goals of risk management include promoting autonomy, ensuring safety, reduction of morbidity and mortality, increasing function, and maximizing quality of life. This physician provided illustrative examples of services that can help promote independence and 'aging in place' such as: support and assistance in the form of home care, day programs, housekeeping, meal delivery and transportation programs (e.g., Access-A-Ride). She emphasized that interventions which explore new ways of addressing the needs of elderly clients in the least restrictive manner possible, while respecting their values and preferences, are

essential. An example provided by Moye and Marson (2007) involves a guardianship hearing resulting in the appointing of a limited guardian (tutor or advisor), who provides support and guidance but has no legal authority to make decisions on behalf of the client.

The Home First Philosophy

In response to long waitlists for beds in long-term care (LTC) facilities, a program called Home First was developed in Ontario, Canada in 2008. This program provides intensive home care, often for several weeks, to clients following discharge from acute care. During this time, the seniors determine their ability to manage in their own home prior to making the difficult decision to transition into an alternate level of care (ALC), such as Long Term Care (LTC) (Health Council of Canada, 2012). This approach provided the opportunity for seniors to make this life altering decision in a familiar environment over time, rather than in a stressful environment such as acute care. The Home First program views a LTC placement as a last resort and only after all community options have been exhausted (Health Council of Canada, 2012).

Technology

According to Hanson, Takahashi and Pecina (2013), advances in communication technology such as telehealth and telecare, which use a telephone or other telecommunication device, assists health care providers to provide support to clients in their own home from a distance. These researchers cite a range of examples, beginning with home telemonitoring, which uses audio, video and other technologies such as a stationary tabletop instrument or laptop, aids in the measurement of biometric parameters, including blood pressure, heart rate, temperature, blood glucose levels, oxygen saturation and weight. They noted the ease by which clients can complete a record of their daily symptoms and transmit their answers and the biometric data to the provider with one keystroke. A third example they cited was portable monitoring devices, which may be placed in adhesive patches, belts, watches or pendant-like devices and have the potential to be linked to a smart phone, that can be carried by clients to provide continuous monitoring of their biometric data. A fourth example that Hanson et al. cited are portable sensors, which are used to both diagnose and monitor treatment, such as recording changes in the movement of a client with Parkinson's disease, and related data, thereby facilitating medication titration when indicated. A fifth example they discussed pertains to the advances that have been made in environmental technologies, which are considered the least obtrusive because they are non-invasive and not attached to the client. An illustrative example of the latter would be a stove sensor, which combines a motion detector to sense activity in the kitchen with a temperature sensor to detect cooking or failure to turn off a burner. They concluded that corporations have identified, developed and marketed new products based on the trend of older adults, who yearn to "age in place" and avoid institutionalization (Hanson et al., 2013, para. 16).

Potential barriers to technology use, according to Hanson et al (2013) include client noncompliance, legal and privacy concerns. They emphasized that the most cited barrier in adopting a home telemonitoring system is the perception of older adults that they will need to incorporate the technology into their daily life. Hanson and his colleagues contend that some studies have indicated that the client's use of telemonitoring technology may decrease over time. Hence, they suggested that perhaps a more passive method of telemonitoring that does not require active input on the part of older people may assist with overcoming this issue.

Community-based Complex Interventions

Beswick, Rees, and Dieppe (2008) have emphasized that a decrease in physical function can lead to a loss of independence in the senior population. They argued that there is an identified need for preventative strategies to reduce hospital readmissions and falls, improve or maintain physical function, decrease disability and promote independence. In their 2008 study, which addressed the question of the effectiveness of community-based complex interventions focused on maintaining physical functioning and independence in the elderly, they identified the following outcomes : “living at home at follow-up, death, nursing home placement, hospital admissions, falls, and physical function” (para. 10). These authors conducted a systematic review of randomised controlled trials (RCT) pertaining to those outcomes to examine the effectiveness of complex interventions used to preserve physical function and independence in the elderly (mean age of at least 65 years).

Beswick et al (2008) defined a complex intervention as a combination of interdisciplinary teamwork and multidimensional assessments of health and social problems. . These British researchers identified 89 randomized clinical trials (RCTs), involving 97, 984 people that indicated that complex interventions can help the elderly to continue to live independently by reducing nursing-home admissions, hospital admissions, falls and improvement of physical function. Although the evidence from their study did not suggest that one system of care was better than another, there is the possibility that tailoring care in respect to an individual’s preferences and needs may be beneficial. A major strength of their review was the inclusion of a very large sample of older people living at home. By contrast, one limitation of this quantitative study was the complete absence of qualitative data available, thereby making the details of care actually received by the individuals difficult to determine.

Beswick et al. (2008) suggested that outcomes such as client empowerment, autonomy and independent decision making may more accurately describe the effect of an intervention for an individual. In relation to physical function, they concluded that: (a) interpretation of the results was restricted because there was selective reporting in people available for the interview and there were large losses to the follow-up population in various RCTs; and (b) the care that has occurred in the last four decades for the elderly in the UK and changes that have taken place in health care suggested that a termination of the existing and well developed services would be unacceptable in supporting independence in the senior population (p. 734[p.9, electronic version]).

Adaptive Equipment and Support Services

A challenge in supporting seniors to live at risk in their own home, according to Gitlin, Szanton and Hodgson (2013) is navigating the unsafe and “unsupportive home” (para. 35). As Hurley and his colleagues (2004) have noted, injuries from accidents are the seventh (in those over 65 years old) and fifth (in those over 85 years old) leading cause of death in the elderly. The latter researchers emphasized a range of environmental factors and personal health changes that make the home environment unsafe for older adults such as uneven floors, poor lighting in a home coupled with the individual’s deteriorating vision, hearing loss, changes in cognition and movement issues due to arthritis or related condition. Improving accessibility to the home and addressing home disrepair can prove to be a challenging task. Interventions such as adapting the physical environment and addition of supportive services within the home can positively

facilitate the challenge of ageing in place and maximize injury prevention. These types of adaptations to the physical environment interventions are discussed next.

Adaptations to the Physical Environment. In his discussion about facilitating ‘ageing in place’, Solomon (2001) noted that a decline in physical function, cognitive function, strength and endurance eventually impairs the ability of seniors to sustain their self care and care of their home. To address these issues, he indicated several interventions that involved adaptations to the physical environment such as adding grab bars in bathing and toileting areas, increasing lighting in dimly lit areas, providing adaptive eating utensils and clothing, converting tubs to shower stalls and installing raised toilet seats). Gitlin and his colleagues (2013), who also discussed how to promote home safety for older adults, emphasized the need for informal and/or formal caregivers to ensure that homes are in good repair and equipment and devices are well-maintained. Their suggestions about common needs to promote safety and security of this population included completing repairs to steps, loose tiles, railings, securing loose wires and servicing assistive devices, such as wheelchairs and grab bars.

Structural barriers in an existing home, such as entrances with steps and narrow doorways, reduce the likelihood of a senior being able to live independently and age in place. The concept of visitability, which has been developed to address this problem, relates to the need to build houses that are “built for a life-time”. According to the American Association of Retired Persons Public Policy Institute (2008), these home designs focus on three main features: a zero-step entrance, wider doorways and a main floor bathroom. They noted that these visitability features are for new house constructions only and thus the challenge remains for increasing accessibility of existing homes.

Support Services. The addition of support services, including transportation to appointments (such as Access-A-Ride), meals-on-wheels and emergency call systems (eg. Lifeline) can also play a role to minimize the risks of seniors living independently in their own home. Home health services that provide assistance with personal hygiene, dressing, toileting and incontinence management, medication assistance, meal assistance and mobilization and transferring assistance can help a senior to remain more independent and minimize fall risk (Alberta Health Services, 2014). Many seniors have lost their traditional sources of support such as their social network / friends due to illness or death. Furthermore, the support of their children may be difficult related to geographical location or availability, thereby increasing their reliance on supportive services to fulfill their needs. Tremethick (1997) has provided evidence for the need of a range of support services to assist those seniors who require assistance with personal and instrumental activities of daily living so that they can continue to live independently and thereby prevent entry to a nursing home. Supportive services also provide surveillance for those living at risk, thereby resulting in earlier intervention by the healthcare team.

Managed Risk Contracts

A managed risk contract, as described by the Canadian Patient Safety Institute (CPSI, 2009), is a tool to assist in balancing dignity and independence with safety. The CPSI indicated the challenges they face when a senior may wish to engage or not engage in particular behaviors, such as declining recommended advice of a healthcare professional. These decisions may not be

compatible with the wishes of the healthcare team. Kane and Levin (1998) defined a managed risk agreement as a mutually-acceptable arrangement that can be used to help resolve some of the ethical conflicts which arise over “safety-freedom tradeoffs” (para. 24). This process is used to examine or resolve issues when healthcare providers become concerned about the risk(s) their client is taking. Jenkins et al. (2006) outlined the 7 steps of the Managed Risk Contract as follows:

- (i) Identify the behavior of concern
- (ii) Define the potential or actual risk and concerns
- (iii) Define likely consequences of the client’s behavior or condition
- (iv) Identify the preferences of all individuals involved, which includes the at-risk client, care providers and family members
- (v) Identify possible solutions or alternatives
- (vi) Acknowledge and accept the possible negative consequences of the behavior and/or actions
- (vii) Chose a solution

In summary, the managed risk contract is put into effect when the client’s preference differs from that of the informal care providers or health professionals. Although questions arise as to whether a managed risk agreement is a legally binding document, Holstein and Mitzen (2001) considered the act of identifying issues is thought to be valuable in itself and may eventually lead to innovative and compromising solutions. They acknowledged that there is limited documentation to support whether a managed risk agreement would provide protection in the case of legal challenge, and that currently there is no official legal format for managed risk contracts and limited models are available for community use.

In addition to the steps discussed above by Jenkins et al. (2006), there are several other factors should be taken into consideration in the creation of a legally binding managed risk contract, including whether or not ...

- (a) healthcare providers have identified individuals with cognitive impairment and whether formal or informal assessments were used in capacity assessment
- (b) there should be mandatory and uniform assessments of competency prior to creating a managed risk agreement
- (c) a guardian or agent should be granted the authority to officiate a managed risk agreement on the client’s behalf
- (d) the managed risk agreement remains legitimate if a client loses capacity to appreciate the consequences of their behavior (Jenkins et al., 2006).

Conclusion

Supporting the elderly client who chooses to live at risk can be a challenging process. The opportunity for growth also carries with it the potential of failure (Parsons, 2009). As nurses, we have the opportunity to self reflect about whose needs are being met, learn to let go of our

insecurities about the unknown and rethink our concept of failure in order to facilitate client independence.

Biopsychosocial interventions assist with this process. The use of ongoing, comprehensive and validated health care team assessments serve to identify the medical, psychological, social, historical and environmental risk factors that if mitigated to the extent possible, increase safety for the client and others. The development of genuinely collaborative relationships, which redefine an adversarial client as one who has the right to self-determination, facilitates discussion and engages the family, health care teams and agencies to support the client's goals. Managed Risk Agreements can help ease healthcare providers' fears, as they clarify and document the process of how the ethical dilemmas created by a client's risk-taking behavior can be addressed and resolved. The legal implications and community application of such agreements are not yet determined or developed. Ongoing and objective competency assessments are critical and differentiate between the client who is unable to comprehend the consequences of his decisions as compared to one who makes choices contrary to the personal beliefs or professional opinions of others. Should legal guardianship be deemed necessary, less intrusive alternatives such as an advisory only role can reinforce client autonomy. Based on the growing trend of the elderly client's desire to remain independent, the design of progressive programs, such as Home First can provide intensive post acute hospital discharge support. During this time, clients are able to make informed treatment decisions of the need for an advanced level of care in a non-threatening environment and at their own pace. Non-medical interventions can also be used to support and manage the at risk client. The incorporation of technology and adaptive equipment into the home can effectively reduce medical and environmental risks. However, client privacy issues related to technology require further exploration.

Progress has been made to support the elderly client who chooses to live at risk. However, further research is needed in order to develop more comprehensive assessments, evidence-informed interventions and re-visit ethical issues and legal responsibilities, to attain positive outcomes for both elderly clients and health care providers.

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